APPLICATION FOR LICENSE TO PRACTICE SPEECH-LANGUAGE PATHOLOGY OR AUDIOLOGY

State Form 37911 (R10 / 2-06)
Approved by State Board of Accounts, 2006

SPEECH LANGUAGE PATHOLOGY AUDIOLOGY BOARD
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, IN 46204
Telephone: (317) 234-2064
E-mail: pla5@pla.IN.gov

***Your Social Security number is being requested by this state agency in accordance with I.C. 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without it.**

APPLICATION FEE	
DATE FEE PAID (*month, day, year*)	
RECEIPT NUMBER	
LICENSE NUMBER	
LICENSE ISSUANCE DATE (*month, day, year*)	

APPLICANT

Attach one (1) passport-quality photograph taken not earlier than one (1) year prior to the date of application.

DO NOT WRITE ABOVE THIS LINE - FOR OFFICE USE ONLY

APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden*)	Social Security number*	
Address (*number and street or rural route*)		
City	State	ZIP code
Date of birth (*month, day, year*)	Place of birth (*city and state or country*)	
Telephone number (*daytime*) ( )	E-mail address	

APPLYING FOR LICENSURE AS: (*Please check one*)

☐ Speech-Language Pathologist ☐ Audiologist

MASTER'S DEGREE GRANTED BY

NAME OF SCHOOL	LOCATION OF SCHOOL	DATE OF GRADUATION (*month, day, year*)

EXAMINATION RECORD

EXAMINATION TAKEN	DATE OF MOST RECENT EXAMIN (*month, d*	HOW MANY TIMES HAVE YOU SAT FOR THIS EXAMINATION
ETS - PRAXIS Series		

DISREGARD THIS SECTION

AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION (ASHA) CERTIFICATION

Do you hold an ASHA certification? ☐ Yes ☐ No

Certification number

Date of expiration (*month, day, year*)

DISREGARD THIS SECTION

PRE-PROFESSIONAL EDUCATION

NAME OF SCHOOL	LOCATION OF SCHOOL	DATES ATTENDED (*month, day, year*)	DEGREE GRANTED

DIRECT SUPERVISED CLINICAL EXPERIENCE

Was your supervised clinical experience completed in a:

☐ Educational Institution ☐ Clinical Program Associated with the Institution

How many hours of supervised, direct clinical experience did you receive?

CLINICAL EXPERIENCE COMPLETED:

PROGRAM / INSTITUTION	SUPE	START DATE *(month, day, year)*	COMPLETION DATE *(month, day, year)*	HOURS COMPLETED

PLEASE DISREGARD THIS SECTION

COMPLETION OF CLINICAL FELLOWSHIP (CFY)

Do you hold or have you held a CFY registration in the State of Indiana?

☐ Yes ☐ No

Registration number	Date of issuance *(month, day, year)*	Date of expiration *(month, day, year)*

Was your clinical fellowship completed in:

☐ Nine (9) consecutive months *(30 hours per week)*
☐ Twelve (12) consecutive months *(25 to 29 hours per week)*
☐ Fifteen (15) consecutive months *(20 to 24 hours per week)*
☐ Eighteen (18) consecutive months *(15 to 19 hours per week)*

SUPERVISOR		ar)	COMPLETION DATE *(month, day, year)*	HOURS WORKED PER WEEK

PLEASE DISREGARD THIS SECTION

STATES LICENSED

LICENSE TYPE	STATE	NUMBER	DATE ISSUED *(month, day, year)*	EXPIRATION DATE *(month, day, year)*	STATUS

LIST ALL PLACES YOU LIVED SINCE GRADUATION

GENERAL LOCATION	DATES *(month, day, year)*

LIST ALL PLACES OF EMPLOYMENT SINCE GRADUATION FROM YOUR MASTER'S DEGREE PROGRAM

NAME AND ADDRESS OF EMPLOYER	RESPONSIBILITIES	DATES OF EMPLOYMENT *(month, day, year)*

If your answer is "Yes" to any of the following, explain fully in a signed and notarized statement, including all related details. Include the violation, location, date and disposition. If malpractice, provide name(s) of plaintiff(s). Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following is grounds for permanent revocation of a license issued pursuant to this application.	
1. Have you ever previously filed an application in the State of Indiana?	☐ YES ☐ NO
2. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit you hold or have held?	☐ YES ☐ NO
3. Have you ever been denied a license, certificate, registration or permit to practice speech-language pathology or audiology or any regulated health occupation in any state (*including Indiana*) or country?	☐ YES ☐ NO
4. Are you now being, or have you ever been, treated for drug or alcohol abuse?	☐ YES ☐ NO
5. Have you ever been convicted of, plead guilty, or nolo contendre to: A. A violation of any Federal, State, or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction? B. Any offense, misdemeanor or felony in any state? (*Except for minor violations of traffic laws resulting in fines.*)	☐ YES ☐ NO ☐ YES ☐ NO
6. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations?	☐ YES ☐ NO
7. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant?	☐ YES ☐ NO
8. Have you ever had a malpractice judgment against you or settled any malpractice action?	☐ YES ☐ NO

APPLICATION AFFIRMATION	
I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.	
Signature of applicant	Date signed (*month, day, year*)

AUTHORIZATION FOR RELEASE OF INFORMATION
I hereby authorize, request and direct any person, firm, corporation, association, organization or institution to release to the Professional Licensing Agency any files, documents, records or other information pertaining to the undersigned requested by the Agency, or any of its authorized representatives in connection with processing my application for a license to practice speech-language pathology or audiology. I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information. A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION	
I hereby swear or affirm, that I have read the above statements and agree to same.	
Signature of applicant	Date signed (*month, day, year*)

VERIFICATION OF SPEECH-LANGUAGE PATHOLOGIST OR AUDIOLOGIST LICENSURE

INSTRUCTIONS: *Type or print the top portion of the verification and send a copy to each state where you hold or have held a license. Request each state to complete and send directly to:*

Professional Licensing Agency
402 West Washington Street, Room W072
Indianapolis, IN 46204
Telephone: (317) 234-2064
Email: pla5@pla.IN.gov

Name *(last, first, middle, maiden)*		Social Security number *
Address (number and street, rural route)		
City	State	ZIP code
Date of birth *(month, day, year)*	Telephone number *(daytime)* ( )	E-mail address

I hereby authorize the State of _____ to furnish the Professional Licensing Agency with the information below.

Signature	Date signed *(month, day, year)*

TO BE COMPLETED BY THE STATE BOARD

License number	Date of issuance *(month, day, year)*	Date of expiration *(month, day, year)*

License issued based upon:
☐ Examination ☐ Endorsement ☐ Certificate of Clinical Competence From ASHA (CCC's)
☐ Other _____

Type of examination: ☐ ETS-PRAXIS Series ☐ State Constructed Examination *(Attach subjects, scores and average)*	Date of examination(s) *(month, day, year)*

Has the license been subject to any disciplinary action? ☐ Yes ☐ No
(Please attach certified copies of any disciplinary action taken by your board.)

FORM COMPLETED BY:

Name	PLEASE AFFIX BOARD SEAL
Title	
State Board	
Date *(month, day, year)*	

VERIFICATION OF EMPLOYMENT / EXPERIENCE

APPLICANT: Complete the top section of this form, then forward it to your employer. You are authorized to photocopy this form as necessary.

Name of applicant (*last, first, middle, maiden or given surname*)		
Address (*number and street or rural route, city, state, and ZIP code*)		
Social Security number *	Date of birth (*month, day, year*)	Telephone number (*daytime*) ( )

I hereby authorize, _____, to furnish the Professional Licensing Agency with the information below.

Signature of applicant	Date (*month, day, year*)

The remainder of this form must be completed, notarized and submitted by the employer. Please mail completed form to: Professional Licensing Agency, 402 West Washington Street, Room W072, Indianapolis, IN 46204.

Name of employer		
Name of business / institution where employed		
Address of business / institution (*number and street, city, state, and ZIP code*)		
Telephone number of business / institution ( )	Date employment began (*month, day, year*)	Date employment ended (*month, day, year*) (*if currently employed, please indicate*)
Number of hours applicant worked per week	Position held	E-mail address

The applicant pursuant to my order, control, and full professional and legal responsibility as an employer has performed the above-indicated experience. I do hereby declare that the information contained herein is true and correct.

SEAL OF NOTARY PUBLIC	Signature
	Printed name
	Title
	Date (*month, day, year*)

ALL INFORMATION ON THIS FORM MUST BE TYPED OR CLEARLY PRINTED.